Appendix: Full Responses to Question number 8:

A) - Additional thoughts:

1. Given the goal of integration of medical, mental health and substance use disorder treatment and streamlining of administration that is envisioned in CalAIM, where does prevention belong in the continuum of response.

   Perhaps early intervention should be the launch pad of the continuum in the managed care health care world and prevention be moved to the CA Department of Public Health where it could thrive using a public health approach and not be negatively impacted by the managed care business and payment models.

2. The current few youth services in the state pubic system are imploding under DMC. Phoenix Houses of California which once was the largest provider of adolescent residential treatment services in the state has closed all of it remaining adolescent residential services. AADAP Mid-Wilshire is closing. Sunny Hills Services closed their DMC Certified residential services a few months ago. Others have closed in the past year. What is going on? What are the drivers of the closures?

   The now defunct DHCS Youth Advisory Group was working on defining a system of care for youth and how can we support this system. I have attached the proceedings and the CSAM Blueprint that came from the Adolescent Treatment Conference that I put together for the Blue Shield of California Foundation 3 years ago. It has been very disappointing that the legislation for the developing a design for an adolescent treatment continuum has been vetoed twice. In each case (Brown/Newsom) the veto message said DHCS was working on this continuum design. Not at all true. It has been lost in DMC Waiver work and we are losing ground.

3. The current DMC Waiver Benefit Definitions and Payment does not reflect adolescent responsive services.

4. The SUD field has a rich history of recovery and wellness values and has much to offer the health care sector in this regard. Community Health Workers and Peer Navigators are components of a recovery approach. The mental health system adopted recovery principles when MHSA was passed.

   Many states have adopted the Recovery Oriented System of Care Principles to embrace the concept of "recovery" on a system level https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

   SUD is a chronic disease needing both medications where appropriate, care coordination for health and medical issues and mental health and behavioral health services and addressing many psychosocial needs. The Recovery Oriented System of Care concepts and values could unite these distinct sectors with different focuses around health, wellness and recovery.

B) - Additional thoughts:

- All the topics mentioned above are good but would recommend some slight modifications: -Second topic in addition to underage drinking focus on prevention of marijuana use. -Fourth topic- in addition to DUI programs, how are SUD programs in general addressing marijuana use given now legal status? Sixth topic- better incorporated into both prevention and treatment systems. Additional Topics for consideration: -
  - Making DMC-ODS system more responsive and appropriate for youth populations including ability to incorporate early intervention, brief interventions, social activities the improve enrollment and retention in SUD treatment.
  - Older Adults and the various systems of care. -Serving Bilingual and/or mono lingual patients (particularly Spanish speaking) and it's related workforce issues.
  - EPSDT as primary payor of Youth SUD treatment and flexibility it affords with various youth appropriate interventions.
  - Alternative payment methods including value based, fee for service, case and/or pay for performance.

- The future needed workforce and establishment of good job recruitment and training access points (e.g. support for additional residents to pick SUD careers and access SUD certification schools).
- Mandatory certification of Outpatient SUD programs
- BH related regulations and opportunities to modify change outdated regulations w/o need to change statues.
- CAL AIMS and role of providers and other stakeholders. -Implementation of patient centered, integrated, whole person healthcare frameworks

C) - Additional thoughts:

- what are the best ways to communicate ongoing activities across systems (such as existing SUD prevention, mental health services, and treatment)?
- How can the BH Sac be leveraged to share and possibly coordinate existing efforts?
- Can updates on Prop 64 Stakeholder Group be shared with and reported out at BH Sac (as well as other prevention work groups?)

D) - Additional thoughts:

- How can DHCS, ABC, DPH, OTS, DMV, and SHSP agencies use cross-system collaboration at the State level to encourage local jurisdictions to adopt CSAP/SPF community-environment prevention initiatives that prevent / reduce impaired driving casualties in a given community (city, town, county)? In California, each year the total number deaths due to impaired driving equals the total number of homicides. POLD data show that 75% of DUI offenders were drinking in hosted settings before their arrest.
- These settings are highly amenable to local prevention initiatives (zoning controls, community info campaigns, RBS training, etc.).
- A Statewide effort to support Community RBS initiatives can have a major impact on impaired-driving casualties if local communities get the help they need. Think Tobacco Control. Think of DADP pump-priming support for CUPs in the mid-80s

E) - Additional thoughts:

Cost/benefit analysis of AOD prevention work. What primary prevention really means and why early intervention clinical services are extremely important AND need to be funded with treatment dollars.

F) - Additional thoughts:

1) Driving Under the Influence (DUI) issues overall (DMV, courts, probation, programs, DUI-drugs, DUI-marijuana)
2) SPF
3) Official communications from DHCS vs communication via the coordinator meeting

G) - Additional thoughts:

What are future potentials for increased funding for prevention services.